Supreme Court, U.S.
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No. 97-98

In The

Supreme Court of the United States

October Term, 1996

PAN-AMERICAN LIFE INSURANCE COMPANY and NATIONAL INSURANCE SERVICES, INC.,

Petitioners,

v.

CYPRESS FAIRBANKS MEDICAL CENTER HOSPITAL,

Respondent.

On Petition For Writ Of Certiorari To The United States Court Of Appeals For The Fifth Circuit

RESPONDENT'S BRIEF IN OPPOSITION

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QUESTION PRESENTED

Whether the Employee Retirement Income Security Act of 1974 ("ERISA") preempts a health care provider's state law cause of action for the negligent misrepresentation of available benefits against an employee welfare benefit plan, its insurer and its administrator and/or whether a state cause of action for negligent misrepresentation by a health care provider, suing as an independent, commercial non-principal ERISA entity rather than an assignee, "relates to" an employee welfare benefit plan as defined by ERISA. 29 U.S.C § 1144(a) (1994).

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RESPONSE TO WRIT OF CERTIORARI

Cypress Fairbanks Medical Center Hospital respectfully moves the Court to deny Pan American Life Insurance Company & National Insurance Services, Inc.'s petition and allow the holding of the Fifth Circuit to stand, which reversed the judgment of the District Court for the Southern District of Texas and remanded the cause to the District Court with directions to remand Respondent's claim to Texas State Court. As addressed below, in spite of Petitioners' assertions to the contrary, the Fifth Circuit, as well as circuits throughout the country have consistently held Respondent's state cause of action is not preempted by ERISA. Therefore, a sufficient basis for review does not exist.

OPINIONS BELOW

The Fifth Circuit Court of Appeal's opinion is attached to Petitioners' Application for a Writ of Certiorari at 1a-12a and is reported at *Cypress Fairbanks Med. Ctr., Inc. v. Pan American Life Ins. Co.*, 110 F.3d 280 (5th Cir. 1997). The opinion of the District Court is unreported and is attached to Petitioners' Application at Appendix 13a-16a.

JURISDICTION

The Court of Appeals entered its judgment on April 17, 1997, which is attached to Petitioners' Application for

Writ of Certiorari at 17a-18a. The jurisdiction of this Court is invoked under 28 U.S.C. § 1254(i) (1994).

STATUTORY PROVISION INVOLVED

Section 514(a) of ERISA, 29 U.S.C. § 1144(a) (1994), provides, in relevant part, that "the provision of this title and Title IV shall supersede any and all state laws insofar as they may now or hereafter *relate to* any employee benefit plan (*emphasis added*).

RESPONDENT'S REPLY

STATEMENT OF THE CASE

Course of Proceedings and Disposition

Respondent, Cypress Fairbanks Medical Center Hospital, filed suit against Petitioners, Pan America Life Insurance Company and National Insurance Services, Inc., in the 334th Judicial District Court of Harris County, Texas, based on negligence, negligent misrepresentations, and violations of Tex. Insurance Code Ann., art. 21.21 (West 1981). Petitioners removed the cause to the United States District Court for the Southern District of Texas, Houston Division. Based on Petitioners' Motion for Summary Judgment, the District Court entered a take nothing judgment against Respondent holding the claims of Respondent were preempted by ERISA. Respondent appealed the District Court's judgment to the United States Court of Appeals for the Fifth Circuit. The Court of Appeals held the District Court erroneously determined

that Respondent's causes of action were preempted by ERISA and reversed the District Court's decision. The Court of Appeals found that since ERISA is not implicated and the preemption of ERISA does not apply to Respondent's cause of action, the case should be remanded to the District Court with directions to remand Respondent's claim to Texas State District Court.

Statement of Facts

On February 1, 1994, two days prior to Jack Schwartz' admission to Respondent hospital, Respondent contacted National Insurance Services, who served as an agent for Pan American Life Insurance Company, to determine the existence and amount of coverage provided to Mr. Schwartz under the insured plan. Pan American Life Insurance Company, through its agent, National Insurance Services verified that Mr. Schwartz was covered under a group insurance policy issued by Pan American and was eligible for benefits under the policy to cover the anticipated treatment. Once again on February 3, 1994, the date of Mr. Schwartz' admission, benefits under the insurance coverage were verified with National. Both verifications were given by National acting as agent for Pan American with express, implied, apparent, and ostensible authority to bind Pan American. In reliance on the two separate verifications of coverage, Cypress admitted Mr. Schwartz for respiratory failure and subsequently treated him. Mr. Schwartz was released on March 19, 1994. The bill for the extensive services provided to Mr. Schwartz totalled $178,215.44. The bill for services rendered to Mr. Schwartz was subsequently submitted to National.

On July 5, 1994, National, acting as an agent of Pan American, sent an explanation of claim benefits stating that Mr. Schwartz' "coverage rescinded" retroactively as of the effective date and refused to pay the claim for the services Respondent rendered. This communication was the first notice of any kind to Respondent that any problems existed regarding the insurance coverage in question, contrary to all other previous representations including two separate pre-admission verifications of coverage. Despite numerous demands for payment and attempts to resolve the matter Petitioners asserted that benefits were not available under the plan and refused to acknowledge that they were liable for the erroneous information on which Respondent detrimentally relied in its admission and treatment of Mr. Schwartz. As a result of this conduct, Respondent was forced to initiate suit against Petitioners for negligent verification of the coverage in question.

ARGUMENT

No Apparent Inter- or Intra-Circuit Conflict Exists Justifying Review of the Case Below.

As shown below, the Fifth Circuit's decisions as well as the decisions of the circuits throughout the country have consistently adopted the reasoning which holds a health care provider's state claim for negligent misrepresentation are not preempted by ERISA. No apparent conflict exists to warrant review of the issue.

Petitioners' assertion that a health care provider's state cause of action for negligent representation as a

third party, non-principal ERISA entity is an attempt to extend the preemption of ERISA beyond the limits consistently recognized by the Fifth Circuit as well as the other circuit court of appeals. Petitioners' position that preemption applies is unfounded, because Respondent brought its claim as a third party, commercial entity, who looked to and relied upon representations made by Petitioners as to the coverage available to a patient admitted and treated at Respondent hospital. At no time did Respondent bring the suit below as an assignee of any plan benefits or assert claims for the recovery of benefits from the plan. The fact is there was no coverage available to the admitted patient according to Petitioners and as such, Respondent could not assert claims to recover under the plan itself. If no benefits were available under the plan, as alleged by Petitioners, then Respondent's claim logically does not seek plan benefits or recovery from the plan itself. Rather, Respondent brought its claims as an independent, third-party commercial entity, unrelated to the plan, and based solely upon misrepresentations negligently made by Petitioners, which Respondent relied upon to its detriment. The claims of Respondent and any damages potentially awarded Respondent would have no effect on the administration of the claim benefits available under the plan, the terms of the plan or the plan itself. *See Memorial Hospital System v. Northbrook Life Insurance Co.*, 904 F.2d 236, 249 (5th Cir. 1990). Petitioners suggest the employee benefit plan itself would directly bear the burden of damages awarded as a result of an insurance company's misrepresentations and negligence. The plan would not pay any damages, but rather its

errors and omissions liability coverage would likely satisfy any award of damages. Therefore any effect on an employee benefit plan, even indirectly, would be too tenuous to justify preemption.

ANALYSIS

29 U.S.C. § 1144(a) provides that:

> except, as provided in subsection (b) of this section, the provision [of ERISA] shall supersede any and all State laws insofar as they may now or hereafter *relate to* any employee benefit plan, . . . [*emphasis added*].

In *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 103 S.Ct. 2890, 77 L.Ed. 2d 490 (1983), this Court held that "a state law relates to an ERISA plan when the state law has a connection with or reference to such a plan." *Shaw*, at 96-97, 103 S.Ct. at 2899-2900. Yet, this Court opined some state actions may affect employee benefits in too tenuous, remote, or peripheral a manner to warrant finding that the law relates to the plan. *Id.* at 100 n. 21, 103 S.Ct. at 2901 n. 21. This Court has cautioned that ERISA preemption analysis must be guided by respect for the separate spheres of governmental authority prescribed in our federalist system. *Fort Halifax Packing Co. v. Coyne*, 482 U.S. 1, 19, 107 S.Ct. 2211, 96 L.Ed. 1 (1987). States must have some semblance of power to regulate commercial conduct as is further evidenced in the savings clause of ERISA. *Memorial Hospital System v. Northbrook Life Insurance Co.*, 904 F.2d 236, 243-44 (5th Cir. 1990); Employment Retirement Income Security Act of 1974, § 514(b)(2)(A), as

amended, 29 U.S.C.A. § 1144(b)(2)(A), (the savings clause provides nothing shall be construed to exempt or relieve any person from any law of any state, which regulates insurance, banking or security). The mere mention of an ERISA plan in a complaint is not, in and of itself, sufficient to warrant a finding that the state law relates to a plan. *Hospice of Metro Denver, Inc. v. Group Health Insurance of Oklahoma, Inc.*, 944 F.2d 752, 754 (10th Cir. 1991). The most important factor in considering whether a state law is preempted is whether the law affects relations among ERISA-named entities – the employer, the plan, the plan fiduciaries and the beneficiaries. *Memorial*, 904 F.2d at 249.

The issue presented to this Court is whether ERISA preempts state tort law claims of negligent misrepresentations by a third party provider who sues the plan and/or the administrator of a plan, *not* as an assignee of an ERISA beneficiary, but as an independent, commercial entity claiming damages. The Fifth Circuit's decision and interpretation of the preemption of state law claims for misrepresentation as well as that of the other circuit court of appeals are consistent and clear as shown below.

Petitioners represent to this Court that the Fifth Circuit Court's decision conflicts with decisions in the Sixth and Eleventh Circuits, as well as other decisions of the Fifth Circuit regarding questions of preemption and creates confusion as to the issue. Actually, the decisions of the Fifth Circuit addressing this issue are clear and consistent, as are the decisions throughout the Circuits, which closely follow and/or parallel the reasoning of the Fifth Circuit in holding state law negligent misrepresentation causes of action are not preempted. Any inter- or

intra-conflicts raised by Petitioners can be attributed to the Petitioners' mischaracterization of the case law upon which they rely. An accurate reading of the same demonstrates the cases are distinguished by the fact Respondent brought its claim as a commercial third party, non-participating ERISA entity, independent and unrelated to the plan, and not as an assignee of a principal ERISA beneficiary, *i.e.*, patient. Therefore Respondent's claim is not preempted, and review by this court is not warranted.

REASONING OF THE FIFTH CIRCUIT IN HOLDING A PROVIDER'S CAUSE OF ACTION IS NOT PREEMPTED BY ERISA

The United States Court of Appeals for the Fifth Circuit in the case before this Court and *Memorial Hospital System v. Northbrook Life Insurance Co.*, 904 F.2d 236 (5th Cir. 1990) has clearly held that a hospital's claim against a group health insurer and/or its administrator for the negligent misrepresentation of available medical coverage is not preempted by ERISA.

As recognized by the Court of Appeals, while "any and all state laws insofar as they now or hereafter relate to any employee benefit plan are preempted by ERISA" the preemptive power of ERISA is not without limit. 29 U.S.C. § 1144(a), *Memorial*, 904 F.2d at 244. In its analysis of the statute the Fifth Circuit recognized ERISA preemption has two unifying characteristics: (1) the state law claims address areas of exclusive federal concern, such as the right to receive benefits under the terms of an ERISA plan; and (2) the claims directly affect the relationship among traditional ERISA entities – the employer, the plan and its fiduciaries, and the participants and beneficiaries.

Id. at 245. The Court of Appeals held *Memorial* and the case below fit into neither category. Rather the health care providers' causes of action for misrepresentation were brought as an independent, third-party provider of medical services. *Id.* This is easily distinguished from bringing a claim derivatively or as an assignee where a medical provider is directly seeking plan benefits while standing in the shoes of a plan beneficiary. *Id.* at 247. Therefore, it was recognized in *Memorial* and in the case below that a third-party health care provider, suing independently for damages resulting from misrepresentations of coverage does not sufficiently justify ERISA preemption in that a hospital's claims for misrepresentation neither address areas of federal concern nor directly affect traditional ERISA entities. *Id.* at 245. Therefore the claims do not "relate to" an employee benefit plan. *Id.*

The Fifth Circuit cited a number of policy considerations in its reasoning. *See Id.* First, if an insurer misrepresents the coverage of a patient, the health care provider's remedy under state law in no way expands the rights of the patient/beneficiary under the health plan. *Id.* at 246. If a patient is not covered, he or she is individually obligated to pay for the medical services. *Id.* The only question is whether the risk of non-payment should remain with the provider or be shifted to the insurance company which misrepresented to the provider that a patient was covered. *Id.* A provider's state law cause of action in these circumstances would not arise due to the patient's coverage under an ERISA plan, but precisely because there is no ERISA plan coverage. *Id.* Simply put, non-derivative state claims do not affect the relations between principal ERISA entities sufficiently to warrant

preemption and the effect of such a cause of action is too tenuous, remote or peripheral to be preempted. *Id.* at 249.

The Fifth Circuit in *Memorial* and the case below also opined that the commercial realities facing third-party providers of health care, dictate hospitals must, and do, rely upon insurance carriers' representations regarding decisions to admit potential patients. *Id.* at 246-247. When an insurance company or its agent verify coverage to a third party, the insured should recognize the commercial implications of its representations to the medical provider. *Id.* at 246. An insurance company is agreeing affirmatively to pay the expenses within the represented terms of the policy or accept the consequences of a false representation of coverage. *Id.* To insulate insurance carriers from liability leaves medical providers with no recourse against the party causing the damages, if it acts and relies on representations of coverage. *Id.* The obligations of the insurance company and its agent to providers is created by its own actions and misrepresentations independent of the plan. *Hoag Memorial Hosp. v. Managed Care Administrators*, 820 F.Supp. 1232 (C.D. Cal. 1993). To hold otherwise would only allow insurance carriers to hide behind a statute enacted to regulate such abuses.

Depriving independent, third-party providers of this state law cause of action does not further, but defeats the congressional purpose of ERISA. *Id.* at 247; *Hospice of Metro Denver, Inc. v. Group Health Ins. of Okla., Inc.*, 944 F.2d 752, 754-55 (10th Cir. 1991). Congress did not intend ERISA to regulate such commercial interactions of such entities in similar situations. *See Hospice*, 944 F.2d at 756; *Memorial*, 904 F.2d at 250; *Forest Springs Hosp. v. Ill. New Car & Truck Dealers*, 812 F.Supp. 729 (S.D. Tex. 1993); *The*

Meadows v. Employers Health Insurance, 826 F.Supp. 1225 (D. Ariz. 1993). If such were the case, health care providers, if anything, would be less likely to accept the risk of non-payment, may demand up-front payment by beneficiaries or impose other inconveniences before treatment is offered. *Memorial*, 904 F.2d at 247. Likewise, Congress surely did not intend to shield welfare plan beneficiaries from the consequences of their acts towards non-ERISA entities such as health care providers, when a cause of action does not relate to the terms and conditions of a welfare plan, nor affect the ongoing administration of a plan. *Id.* at 250. To hold to the contrary would leave health care providers no recourse for the misrepresentations of carriers as to the coverage of admitted patients, which is attributed only to the carrier's negligence.

In a similar vein, this Court has held state causes of action may be brought against ERISA plans, and the preemptive power of ERISA is limited when claims do not arise under the plan because the claims are not specific to a plan or a beneficiary. *Mackey v. Lanier Collection Agency and Service, Inc.*, 486 U.S. 825, 832-33 (1988) (Georgia's general garnishment law is not preempted despite the fact the garnishment mechanism can subject a plan to administrative costs and burdens); *Abofreka v. Alston Tobacco Co.*, 288 S.Ct. 122, 341 S.E. 2d 622 (1986) (Cited by this Court in *Mackey* stating a doctor's claim against an employee and its benefit plan for libel not preempted). The Court made a distinction between enforcement actions brought *by* ERISA entities to secure certain specified relief compared to lawsuits against plans for run-of-the-mill state law claims and even torts committed by an

ERISA plan involving claims brought by non-ERISA entities. *Mackey,* 486 U.S. at 833 and n. 8, 108 S.Ct. at 2187 and n. 8. While the claims may tangentially involve ERISA plans, they are not preempted. *Memorial,* 904 F.2d at 248. Claims for negligent misrepresentations by providers do not affect relations among ERISA named principal entities and at the most relate to a plan too tenuously or remotely to justify preemption. *Id.* at 249; *See also, Sommers Drug Stores Co. Employee Profit Sharing Trust v. Corrigan Enterprises, Inc.,* 793 F.2d 1456, 1467-68 (5th Cir. 1986), *cert. denied,* 479 U.S. 1034, 107 S.Ct. 884, 93 L.Ed. 2d 837 (1987), *Perkins v. Time Insurance Co.,* 898 F.2d 470, 473 (5th Cir. 1990).

The most important factor for determining whether a state law affects a plan in too tenuous, remote, or peripheral a manner to be preempted is simply whether the state law affects relations among ERISA named entities, rather than relations between ERISA entities and outside independent parties. *See Memorial,* 904 F.2d at 249; principle reaffirmed in *Perkins v. Time Ins. Co.,* 898 F.2d 470, 473 (5th Cir. 1990). Such is the immediate case. In no way does Respondent's cause of action relate to the terms or conditions of a plan, modify them, nor affect the administration of the same nor is a health care provider an ERISA entity governed by the statute for purposes of claims of negligent misrepresentation.

THE FIFTH CIRCUIT'S HOLDING IN THIS CASE AND *MEMORIAL* IS CONSISTENT WITH HOLDINGS IN THE OTHER CIRCUITS

Despite Petitioners' claim to the contrary, the holding of the Fifth Circuit and the reasoning adopted in this case

and *Memorial* is uniformly consistent in other circuits. Any alleged conflict asserted by Petitioners is properly distinguished.

In their brief Petitioners claim that the Fifth Circuit's decision conflicts with decisions in the Sixth and Eleventh Circuits. Petitioners' interpretation of the case law it relies upon is misplaced, lacks precedential value, and actually supports Respondent's position.

As cited by Petitioners, this Court in *Pilot Life* stated the policy choices in ERISA would be undermined if ERISA plan, participants and beneficiaries were free to obtain remedies under state law that Congress rejected in ERISA. *Pilot Life Insurance Co. v. Dedaux* 481 U.S. 41 (1987). While this is true, a third party health care provider is not an ERISA plan participant, and is not listed as such. *See Memorial* at 249. Petitioners assert that *Pilot Life* was subsequently followed, holding state laws of action were preempted. While this is also true, the cases cited by Petitioners simply do not involve a third-party health care provider bringing an independent cause of action for negligent misrepresentations against an insurance carrier. *See American Federation of Unions Local 102 v. Equitable Life Assurance Society,* 841 F.2d 658 (5th Cir. 1988) (Union, unions health and welfare fund and two plan participants brought action against insurer and administrator of fund, alleging breach of fiduciary duties); *Howard v. Parisian, Inc.,* 807 F.2d 1560 (11th Cir. 1987) (former employee brought action to recover additional health care benefits under benefit plan for bad faith refusal to pay benefits and infliction of emotional distress); *Kanne v. Connecticut General Life Insurance Co.,* 867 F.2d 489 (9th Cir. 1988) (Suit brought by beneficiaries against group health insurer

alleging breach of contract, breach of covenant of good faith and fair dealing and breach of fiduciary and statutory duties). In none of these cases in which Petitioners' claim follows the reasoning of *Pilot Life*, was the suit filed by a third party health care provider. Rather, all were brought by plan participants and/or ERISA entities. Therefore, Respondent's claims do not undermine or conflict with the precedents of this Court.

Likewise, Petitioners claim a conflict arises in the Eleventh Circuit's opinion in *Lordmann Enters, Inc. v. Equicor, Inc.*, 32 F.3d 1529 (11th Cir. 1994), *cert. denied*, 116 S.Ct. 335 (1995). There is no conflict, as *Lordmann* clearly holds a third-party health care provider's negligent misrepresentation claim does not relate to a health benefit plan and was not preempted by ERISA. Moreover, the *Lordmann* case cites to, relies upon, and adopts the reasoning of the Fifth Circuit's opinion in *Memorial*, 32 F.3d 1529 at 1533. *See also Clark v. Coats and Clark*, 865 F.2d 1237, 1243-44 (11th Cir. 1989) (tort claim which had no effect on administration of employee benefit plan not preempted). The Petitioners' attempt to create a conflict in *Lordmann* is misplaced and not logically concluded. *Lordmann* and *Clark* clearly follow *Memorial* and the reasoning of the Fifth Circuit, as well as the Tenth Circuit in *Hospice of Metro Denver, Inc. v. Group Health Insurance*, 944 F.2d 752 (10th Cir. 1991). *See Lordmann*, 32 F.3d at 1533. Petitioners' allegations that a different standard was adopted in *Lordmann* does not accurately reflect the holding and reasoning of the Court. Petitioners contend that since the beneficiary *was* covered by the plan in *Lordmann*, this in some way conflicts with the Fifth Circuit in *Memorial*, where the beneficiary was not allegedly

covered under the plan. First, this is a distinction without a difference. In *Lordmann*, the plan provided for thirty days of home nursing care per calendar year. The health care provider's claims were based upon alleged representations that coverage extended beyond the thirty days. *See Lordmann*, 32 F.3d at 1531. The medical provider was compensated for the first thirty days, and disputed the days of treatment for which the patient was allegedly *not* covered. *Id.* at 1530-31. Therefore, Petitioners' assertion that the patient was covered by the plan mischaracterizes the facts.

Regardless, an accurate reading of the case demonstrates the court in *Lordmann* adopted and strictly adhered to the Fifth Circuit's decision and standard in *Memorial*. *See Lordmann*, 32 F.3d at 1533-34. As noted by the *Lordmann* court, the facts are very similar to that of *Memorial* in that a covered dependent sought care at a medical provider, contacted the plan as to coverage and the claim for payment was subsequently denied. *Id.* at 1533. The Eleventh Circuit adopted *Memorial*'s reasoning and held health care providers were beyond the scope of ERISA, preemption would not serve the Congressional purpose of ERISA, and a health care provider's claim against a provider of insurance for negligent misrepresentation affects the relationship between the principal ERISA entity at best only indirectly. *Lordmann*, 32 F.3d at 1533 (*citing Memorial*, 904 F.2d at 245-46 and 248-49). Therefore, ERISA does not preempt a health care provider's claim for negligent misrepresentation. *Id.* at 1534.

Petitioners additionally rely on the Fourth Circuit's opinions in *Healthsouth Rehabilitation Hospital v. American National Red Cross*, 101 F.3d 1005 (4th Cir. 1996), *cert.*

denied, 138 L.Ed. 2d 194 (1996). Once again, the Petitioners mischaracterize what they perceive as conflict in the circuits. The hospital in *Healthsouth* did not bring a cause of action for misrepresentation as a third party, independent claimant, and Petitioners' reliance on the case is misplaced.

Petitioners further state what they perceived as "widespread conflicts" which exist in other circuits, relying on *Decatur Memorial Hospital v. Connecticut General Life Insurance Co.*, 990 F.2d 925, 927 (7th Cir. 1993). Yet in *Decatur*, the hospital's cause of action was brought as an assignee of the beneficiaries' rights and moreover, Illinois law did not provide the hospital with a negligent misrepresentation claim. *See Decatur*, 990 F.2d at 927-28. Likewise in *Coonce v. Aetna Life Ins. Co.*, 777 F.Supp. 759 (D.M.O. 1991), the claim was once again brought by a plan participant or beneficiary, not a third-party health care provider. *Coonce*, 777 F.Supp. at 762.

Lastly, the Petitioners rely upon the Sixth Circuit holding in *Cromwell v. Equicor-Equitable HCA Corp.*, 944 F.2d 1272 (6th Cir. 1991). *Cromwell* is likewise distinguished by the fact the provider asserted its claims as an assignee. As noted by the court in *Cromwell*, the medical provider repeatedly relied on the assignment and their rights thereunder. *Cromwell*, 944 F.2d at 1277. Respondent at no time has asserted rights or claims as an assignee. *Cromwell* additionally relies upon and cites the Fifth Circuit opinion in *Hermann Hosp. v. MEBA Medical & Benefits Plan*, 845 F.2d 1286 (5th Cir. 1988). As addressed more specifically below, *Hermann* is easily distinguished from *Memorial* and the case below in that the medical provider brought its claim as an assignee of benefits to a plan,

rather than a third-party non-ERISA entity. *Memorial*, 904 F.2d at 236. As addressed in *Memorial*, there is a grand distinction between seeking plan benefits as an assignee and bringing a state claim as an independent, third-party commercial entity. *Id.* at 250. As noted in the dissenting opinion of *Cromwell*, while it is clear Congress intended ERISA preemption to be broad, it is not without limitation. *Cromwell*, 944 F.2d at 1283. As this Court held in *Shaw*, some state actions affect employee benefit plans in too peripheral a manner to warrant a finding the law "relates to" a plan. *Shaw v. Delta Airlines, Inc.*, 463 U.S. 85, 100 n. 21, 103 S.Ct. 2890-01 n. 21, 77 L.Ed. 2d 490 (1983). Likewise, the Court's assertion in *Cromwell* that a medical provider's state claim for misrepresentations is a claim for a recovery of benefits of ERISA plans and allowing such claims would somehow affect the relationship between plan principals by extending coverage beyond the terms of the plan is unfounded. First, the damages sought by health care providers would not come from the plan itself, but in all likelihood from the carrier's errors and omissions policy. Likewise, if a patient is not covered, despite an insurance carrier's assertions to the contrary, the provider's civil remedy in no way expands the rights of the patient to receive benefits under the terms of the plan. *Memorial*, 904 F.2d at 246. If the patient is not covered, he or she is individually obligated to pay for charges incurred, not the plan. *Id.* The only question is whether the risk of non-payment remains with the provider or is to be shifted to the insurance company which misrepresented coverage. *Id.* Therefore, a provider's state law claims do not relate to a plan nor affect the same, but simply arise as a result of a carrier's own negligence in

misrepresenting the coverage of patients and specifically arise because there is no coverage. *See Id.*

In spite of the obvious distinctions in the cases relied on by Petitioners, the Respondent additionally refers this Court to the following decisions which affirmatively hold a cause of action by a health care provider for negligent misrepresentations is not preempted by ERISA and demonstrate no conflicts exist to warrant the court hearing this issue. *Hospice of Metro Denver v. Group Health Insurance*, 944 F.2d 752 (10th Cir. 1991) (adopting the reasoning and following *Memorial*); *Lordmann Enters, Inc. v. Equicor, Inc.*, 32 F.2d 1529 (11th Cir. 1994), *cert. denied*, 116 S.Ct. 335 (1995) (following and adopting the holding in *Memorial*); *Clark v. Coats and Clark*, 865 F.2d 1237 (11th Cir. 1989) (*cited* by *Hospice* holding tort claim has no effect on administration of benefit plan and not preempted); *Uselton v. Commercial Lovelace Motor Freight, Inc.*, 940 F.2d 564, 583 (10th Cir. 1991), *cert. denied*, 502 U.S. 983, at 932, 112 S.Ct. 589 (1991) (cause of action affects plan in too tenuous a manner to be preempted); *Settles v. Golden Rule*, 927 F.2d 505, 509 (10th Cir. 1991) (claim too tenuous to be preempted); *Ethridge v. Harbor House Restaurant*, 861 F.2d 1389, 1404 (9th Cir. 1988) (ERISA preempts only state law claims that arise out of the administration of a plan); *The Meadows v. Employers Health Insurance*, 47 F.3d 1006, 1101 (4th Cir. 1995) (negligent misrepresentation claim not preempted where hospital sued independently and not as assignee of benefits); *In Home Health v. Prudential Insurance Co. of America*, 101 F.3d 600 (8th Cir. 1996) (provider's negligent misrepresentation claim not preempted, *citing Memorial*); *Rebaldo v. Cuomo*, 749 F.2d 133, 138 (2nd Cir. 1984); *See also, Wiesenberg v. Paul Revere Life Insurance Co.*,

887 F.Supp. 1529 (S.D. Fla. 1995) (negligent misrepresentation state law claim not preempted, *citing Memorial*); *Hoag Memorial Hospital v. Managed Care Administrators*, 820 F.Supp. 1232 (C.D. Cal 1993) (*citing and adopting Memorial*'s reasoning); *Rehabilitation Institute of Chicago v. Group Administrators*, 844 F.Supp. 1275 (N.D. Ill. 1994) (third-party health provider not party to ERISA and state law doctrine of estoppel not preempted).

As indicated above, the reasoning of the Fifth Circuit has been consistently followed throughout the circuits and any conflicts perceived by Petitioners are easily distinguished and differentiated. Simply put, all of the above courts held that a hospital's independent, third-party cause of action for negligent misrepresentation does not relate to the plan or the administration of the plan, and any effect is tenuous at best. Any perceived conflict by Petitioners is distinguished by reason that the health care provider asserted claims as an assignee standing in the shoes of a beneficiary or ERISA plan participant. Therefore, preemption is not justified and intervention by this Court is unwarranted.

NO CONFLICTS EXIST IN THE FIFTH CIRCUIT

Petitioners contend intra-circuit conflicts exist within the Fifth Circuit between the opinion below, *Memorial* and *Hermann Hosp. v. MEBA Med. and Benefits Plan*, 959 F.2d 569 (5th Cir. 1992). As noted by this Court, ordinarily a conflict between decisions rendered by the same court of appeals is not a sufficient basis for granting a writ of certiorari. *See Davis v. United States*, 417 U.S. 333, 340 (1974). Regardless, as explained in the decision below and

the above cases, the causes of action are easily discernable, distinct, and differentiated. As Respondent has addressed above, in *Memorial* the hospital brought a third-party independent claim for negligent misrepresentation. In *Hermann*, the hospital's claim was based on the assignment of benefits executed by the patient. *Hermann* did not assert violations of the Texas Insurance Code nor bring an independent third-party action as did the provider in *Memorial* and the Respondent in the case below. *Hermann's* claims sought the direct recovery of plan benefits and the claims were dependent on and derived directly from the rights of the plan beneficiaries. *Hermann* stepped into the shoes of the beneficiary – Respondent has not. Respondent has filed an independent claim unrelated to the plan based strictly on its commercial relationship with the carrier and the misrepresentations made to the Respondent, on which it relied to its detriment.

Moreover, as noted in the opinion below, an important element of the holding in *Hermann* was the Court of Appeal's reading of this Court's decision in *Pilot Life Insurance Co. v. Dedeaux*, 481 U.S. 41, 107 S.Ct. 1549, 95 L.Ed. 2d 39 (1987), and *Metropolitan Life Insurance Co. v. Taylor*, 481 U.S. 58, 107 S.Ct. 1542, 95 L.Ed. 2d 55 (1987). The Court of Appeals reasoned that these cases stood for the proposition that where a claim relates to an employee benefit plan governed by ERISA and is based upon state laws of general application and not a law regulating insurance, the state law cause of action is preempted. *Hermann Hospital v. MEBA Medical and Benefits Plan*, 845 F.2d 286, 1290 (5th Cir. 1988). Yet states must have some semblance of power to regulate insurance companies and their commercial conduct as evidenced in the savings

clause of ERISA. *Memorial*, at 243-244; Employee Retirement Income Security Act of 1974, § 514(b)(2)(A), as amended, 29 U.S.C.A. § 1144 (b)(2)(A) (savings clause provides nothing shall be construed to exempt or relieve any person from any law of any state which regulates insurance, banking and security). Respondent's third-party cause of action under the Texas Insurance Code for negligent misrepresentation clearly falls within areas reserved for state regulaton.

As expressed in the opinion below, the difference between *Hermann* and *Memorial* has nothing to do with the bare existence of an ERISA plan. Rather, the proper inquiry is whether the beneficiary under the ERISA plan was covered by the terms of the health care policy, because if the beneficiary was not, the provider of health services acts as an independent third-party. Respondent was acting merely as a commercial entity in its reliance on Petitioners' representatons, completely outside of any relation to the benefit plan. *Memorial*, at 249-50. This type of commercial relationship between carrier and a health care provider, not an ERISA plan participant supports the reasoning in *Memorial*, holding that a hospital is not a principal ERISA entity as intended by Congress. *Id.* at 250. Respondent's available recourse in the event of a carrier's own negligence is predicated on the classically important state interest in allocating negligence and support damages between commercial entities operating within a state, particularly the insurance industry as addressed in ERISA. *Id.* at 246. Moreover, any damages for which Respondent sues result solely from the misrepresentations made by the insurance company and/or its

agents and remain distinct and separate from the plan itself. *Id.* at 250.

Petitioners' perception of an intra-circuit conflict with *Hermann* simply ignores the obvious distinction between employer-employee cases brought by ERISA plan participants and the case below.

PETITIONERS HAVE FAILED TO DEMONSTRATE INTER- AND INTRA-CIRCUIT CONFLICTS

Petitioners would have this Court believe inter- and intra-circuit conflicts regarding the issue of ERISA pre-emption as it applies to state law claims for negligent misrepresentations by independent third-party health care providers has created confusion in the decisions throughout the circuits and this Court.

Clearly, Petitioners have failed to see the bright line distinction created by the courts between suits brought by ERISA entities such as plan participants which have been held to be preempted, and claims brought by non-ERISA, third-party health care providers, who bring claims not as assignees of plan benefits, but as independent commercial entities who have relied on negligent misrepresentations to their detriment.

The reasoning of the Fifth Circuit and all the courts cited above clearly demonstrate not only consistent holdings and reasoning throughout the circuits, but also clearly follow the precedent and guidelines set forth by this Court in *Shaw v. Delta Airlines, Inc.*, 463 U.S. 85 (1983) and *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41 (1987). The Petitioners' attempts to create conflicts and misapply the cases they cite are attempts to mislead this Court and its

reliance on cases in which providers bring claims as assignees of plan benefits is distinct from Respondent's claims.

Therefore, no genuine conflicts exist justifying review by this Court.

CONCLUSION

This case does not merit review by this Court. For the foregoing reasons, Petitioners' Application for Writ of Certiorari should be denied.

Respectfully submitted,

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